CHAPTER NO. 780

SENATE BILL NO. 93

By Harper

Substituted for: House Bill No. 976

By Kernell, Cooper, Brooks

AN ACT To amend Tennessee Code Annotated, Title 4, Chapter 29 and Title 68, Chapter 11, relative to the Health Facilities Commission.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Section 4-29-222(a), is amended by deleting item (20) in its entirety.

SECTION 2. Tennessee Code Annotated, Section 4-29-225(a), is amended by adding two (2) new items thereto, as follows:

( ) Health Services and Development Agency, created by this act;

( ) State Health Planning and Advisory Board, created by this act;

SECTION 3. Tennessee Code Annotated, Title 68, Chapter 11, Part 1, is repealed in its entirety effective July 1, 2002.

SECTION 4. Tennessee Code Annotated, Title 68, Chapter 11, is amended by adding a new Part 16 as follows:

Section 68-11-1601. This part shall be known and may be cited as the "Tennessee Health Services and Planning Act of 2002".

68-11-1602. As used in this part, unless the context otherwise requires:

(1) "Agency" and "Health Services and Development Agency" means the agency created by this part to administer the certificate of need program and related activities;

(2) "Board" and "state planning and advisory board" mean the board created by this part to develop the state health plan and other related studies;

(3) "Certificate of need" means a permit granted by the Health Services and Development Agency to any person for the establishment or modification of a health care institution, facility, or covered health service, at a designated location;

(4) "Conflict of interest" means any matter before the agency in which the member or employee of the agency has a direct or indirect interest which is in conflict or gives the appearance of conflict with the discharge of the member's or employee's duties;

(A) "Direct interest" means a pecuniary interest in the persons involved in a matter before the agency. This interest

applies to the agency member or employee, the agency member's or employee's relatives or an individual with whom or business as to which the member or employee has a pecuniary interest. For the purposes of this act, a relative is a spouse, parent, child, stepparent, stepchild, grandparent, grandchild, brother, sister, half-brother, half-sister, aunt, uncle, niece, or nephew by blood, marriage or adoption; and

(B) "Indirect interest" means a personal interest in the persons involved in a matter before the agency that is in conflict or gives the appearance of conflict with the discharge of the agency member's or employee's duties;

(5) "Department" means the Department of Health;

(6) "Ex Parte communications" mean communications as defined by § 4-5-304;

(7) "Facility" means any real property or equipment owned, leased, or used by a health care institution for any purpose, other than as an investment;

(8)(A) "Health care institution" means any agency, institution, facility or place, whether publicly or privately owned or operated, which provides health services and which is one (1) of the following: nursing home; recuperation center; hospital; ambulatory surgical treatment center; birthing center; mental health hospital; mental retardation institutional habilitation facility; home care organization or any category of service provided by a home care organization for which authorization is required under Part 2 of this chapter; outpatient diagnostic center; rehabilitation facility; residential hospice; non-residential methadone treatment facility or mental health residential treatment facility;

(B) "Health care institution" does not include:

(i) Ground ambulances;

(ii) Homes for the aged;

(iii) Any premises occupied exclusively as the professional practice office of a physician licensed pursuant to the provisions of Title 63, Chapter 6, Part 2 and Title 63, Chapter 9, or dentist licensed by the state and controlled by such physician or dentist;

(iv) Administrative office buildings of public agencies related to health care institutions; or

(v) Christian Science sanatoriums operated, or listed and certified, by the First Church of Christ Scientist, Boston, Massachusetts;

(9) "Health service" means clinically related (i.e., diagnostic, treatment, or rehabilitation) services and includes those services specified as requiring a certificate of need under § 68-11-1607;

(10) "Home care organization" means any entity licensed as such by the department which is staffed and organized to provide "home health services," or "hospice services" as defined by § 68-11-201, to patients in either their regular or temporary place of residence;

(11) "Letter of intent" means the form prescribed by the agency which shall require a brief project description, location, estimated project cost, owner of the project and description of services to be performed;

(12) "Licensed beds" means the number of beds licensed by the agency having licensing jurisdiction over the facility;

(13) "Major medical equipment" means a single unit of medical equipment or a single system of components with related functions, which is used to provide medical and other health services and which costs more than the amounts determined under § 68-11-1607(a); "major medical equipment" does not apply to any equipment not directly related to patient care;

(14) "Patient" means and includes, but is not limited to, any person who is suffering from an acute or chronic physical or mental illness or injury or who is crippled, convalescent, infirm, or mentally retarded, or who is in need of obstetrical, surgical, medical, nursing, psychiatric or supervisory care;

(15) "Person" means any individual, trust or estate, firm, partnership, association, stockholder, joint venture, corporation or other form of business organization, the State of Tennessee and its political subdivisions or parts thereof, and any combination of persons herein specified, public or private; "person" does not include the United States or any agency or instrumentality thereof, except in the case of voluntary submission to the regulations established by this part;

(16) "Rehabilitation facility" means an inpatient or residential facility which is operated for the primary purpose of assisting in the rehabilitation of physically disabled persons through an integrated program of medical and other services which are provided under professional supervision;

(17) "Review cycle" means the timeframe set for the review and initial decision on applications for certificate of need applications that have been deemed complete. The first day of the month is the first day of the review cycle; and

(18) "State health plan" means the plan that is developed by the state planning and advisory board pursuant to this part. The plan shall include clear statements of goals, objectives, criteria and standards to guide the development of health care programs administered or funded by the State of Tennessee through its departments, agencies or programs, and used by the agency when issuing certificates of need.

Section 68-11-1603. It is hereby declared to be the public policy of this state that the establishment and modification of health care institutions, facilities and services shall be accomplished in a manner which is orderly, economical and consistent with the effective development of necessary and adequate means

of providing for the health care of the people of Tennessee. To this end, the provisions of this section shall be equitably applied to all health care entities, regardless of ownership or type, except those owned and operated by the United States government.

Section 68-11-1604. (a) There is hereby created a Health Services and Development Agency which has jurisdiction and powers relating to the certification of need and related reporting of all health care institutions, as defined by and subject to this chapter.

(b)(1) The agency shall have nine (9) members including the Comptroller of the Treasury or an employee of such department upon the designation of the Comptroller of the Treasury, the state director of TennCare or its successor or an employee of such department upon the designation of the director, the Commissioner of the Department of Commerce and Insurance or an employee of such department upon the designation of the commissioner, one (1) consumer member appointed by the Speaker of the Senate, one (1) consumer member appointed by the Speaker of the House of Representatives and five (5) members appointed by the Governor which include one (1) person who has recent experience as an executive officer of a hospital or hospital system from a list of one (1) nominee submitted by the Tennessee Hospital Association; one (1) representative of the nursing home industry from a list of one (1) nominee submitted by the Tennessee Health Care Association; one (1) duly licensed physician from a list of one (1) nominee submitted by the Tennessee Medical Association; and one (1) consumer member.

(2) In making appointments to the health services and development agency, the Governor and the speakers shall strive to ensure that racial minorities, females, persons sixty (60) years of age and older and the three (3) grand divisions of the state are represented.

(3) The consumer members shall be persons who are knowledgeable of health needs and services and who are further knowledgeable by training or experience in health care facility design or construction, financing of health care services or construction, reimbursement of health care services, or general health care economics. The consumer members shall not be a direct provider of health care goods or services.

(c)(1) No member of the agency shall serve beyond the expiration of such member's term, whether or not a successor has been appointed by the Governor or the speakers.

(2) Except for the Comptroller of the Treasury, the Commissioner of the Department of Commerce and Insurance, the Director of TennCare, or their appointed employees, agency members shall be appointed for three-year terms and no member shall serve more than two consecutive three-year terms. The terms shall be staggered so that the initial term for the physician and the consumer member appointed by the Governor shall be three (3) years; the consumer member appointed by the Speaker of the Senate shall be one (1) year; and the nursing home representative, the hospital representative and the consumer member appointed by the Speaker of the House of Representatives shall be two (2) years. Following the initial terms, all terms shall be three years.

(3) If any member is absent from three (3) consecutive, regularly scheduled public meetings of the agency, such individual's membership shall be automatically terminated, and the position shall be considered as vacant.

(d)(1) Each member of the agency shall receive fifty dollars ($50.00) per diem when actually engaged in the discharge of such member's official duties, and in addition, shall be reimbursed for all travel and other necessary expenses. However, agency members that are state employees shall not receive such per diem but shall be reimbursed for all travel and other necessary expenses.

(2) All expenditures shall be claimed and paid in accordance with the provisions of the comprehensive travel regulations as promulgated by the Department of Finance and Administration, and approved by the Attorney General and Reporter.

(e)(1) The agency, at its first meeting and the first meeting in each second fiscal year thereafter, shall elect one of the consumer members as chair of the agency for a term of two years. No member shall serve consecutive terms as chair. At the same meeting, the agency shall elect from its members a vice- chair to serve a term of one year. No member shall serve two consecutive terms as vice-chair.

(2) Meetings of the agency shall be held as frequently as its duties may require.

(3) Six (6) members shall constitute a quorum, but a vacancy on the agency shall not impair its power to act.

(4) No action of the agency shall be effective unless such action is concurred in by a majority of its members present and voting.

(5) In the event of a tie vote, the action shall be considered disapproved.

(6) The agency shall record by name the votes taken on all actions of the agency.

(7)(A) All agency members shall annually review and sign a statement acknowledging the statute, rules and policies concerning conflicts of interest.

(B) Any member, upon determining that a matter scheduled for consideration by the agency results in a conflict with a direct interest shall immediately notify the executive director and shall recuse himself or herself from any deliberation of the matter, making any recommendation or testifying concerning the matter or voting on the matter. The member shall join the public during the proceedings.

(i) Any member with an indirect interest shall publicly acknowledge such interest.

(ii) All members shall make every reasonable effort to avoid even the appearance of a conflict of interest. If a member is uncertain whether the relationship justifies recusal, the member shall follow the determination by the legal counsel for the agency.

(iii) A determination by the agency or any court that a member of the agency with a direct interest failed to provide notice and recuse from deliberations of the matter, making any recommendation or testifying concerning the matter or voting on the matter shall automatically be terminated from the agency and the position shall be considered vacant. The member shall not be eligible for appointment to any agency, board or commission of the state for a period of two years.

(iv) The executive director, upon determining that a conflict exists for the executive director or any member of the staff, shall notify the chairman of the agency and take such action as they prescribe and pursuant to this part.

Section 68-11-1605. In addition to the powers granted elsewhere in this part, the agency has the duty and responsibility to:

(1) Receive and consider applications for certificates of need, to review recommendations thereon, and to grant or deny certificates of need on the basis of the merits of such applications within the context of the local, regional and state health needs and plans, including, but not limited to, the state health plan developed pursuant to § 68-11-1625, in accordance with the provisions of this part;

(2) Consider and make recommendations and comment to the Governor concerning the state health plan as developed and submitted by the state health planning and advisory board;

(3) Promulgate rules, regulations and procedures deemed necessary by the agency for the fulfillment of its duties and responsibilities under this part and contract when necessary for the implementation of the certificate of need program and health planning as defined by this part; and

(4) Weigh and consider the health care needs of consumers, particularly women; racial and ethnic minorities; TennCare/Medicaid recipients and low-income groups whenever the agency performs its duties or responsibilities assigned by law.

Section 68-11-1606. (a) The agency shall appoint an executive director qualified by education and experience. The executive director shall demonstrate knowledge and experience in the areas of public administration and health policy development.

(b) The agency shall fix the salary of the executive director, who shall serve at the pleasure of the agency. The executive director shall be the chief administrative officer of the agency and the appointing authority, exercising general supervision over all persons employed by the agency.

(c) The executive director shall have the following duties:

(1) Keep a written record of all proceedings and transactions of the agency, which shall be open to public inspection during regular office hours;

(2) Administer the certificate of need process;

(3) Represent the agency before the General Assembly;

(4) Oversee the issuance of responses to requests for determination regarding the applicability of the provisions of this part;

(5) Prepare the agenda, including consent and emergency calendars, and notice to the general public of all meetings and public hearings of the agency;

(6) Employ such personnel, within the budget, to assist in carrying out the provisions of this part; and

(7) Carry out all policies, rules and regulations that are adopted by the agency and supervise the expenditure of funds.

(d) In addition to the duties provided in subsection (c), the agency shall have the authority to delegate, and it is the intent of the General Assembly that the agency exercises such authority to delegate, the following responsibilities and duties to the executive director:

(1) Granting approval, denial deferral or referral to the agency of applications for certificate of need in accordance with §68-11-1609; and

(2) Granting approval or denial of modifications, changes of conditions or ownership, and extensions of certificates of need as in accordance with provisions of this part.

(e) The delegation of authority pursuant to §68-11-1606(d) shall continue until specifically revoked by the agency as a result of a determination that such revocation is necessary to insure the proper and orderly operations of the agency.

(f) Actions taken by the executive director shall be final as if the actions were taken by the agency; provided, that a member of the agency may, in the sole discretion of the member, request that the agency review the action of the executive director. Such request shall be made within fifteen (15) days of the notice of the action by the executive director, in which case the action shall not become final until the agency has rendered its final decision in the matter. The review shall be heard within forty-five (45) days of the request for review of the action.

(g) A party desiring the agency to review an action by the executive director must file a written petition for review with the agency within fifteen (15) days of notice of the action. The executive director shall notify the members within two (2) business days that a request for agency review of the initial action has been filed. Any member of the agency shall have fifteen (15) days to request an agency review. If no member requests a review within said fifteen (15) days,

such petition shall be deemed denied. If the agency grants the petition to review of the initial action of the executive director, the agency shall set a public hearing reviewing the action. The public hearing shall be held within forty-five (45) days from the date the review was requested by the member. This shall not be construed to limit in any way the authority of any agency member to request a review within fifteen (15) days of the notice of the initial action of the executive director.

(h) All reviews by the agency of decisions made by the executive director shall be upon the written notice of the action of the executive of the director, the application file, reports from the appropriate reviewing agency, or such information as the agency shall direct.

(i) If the agency does not exercise its discretion to review a decision of the executive director, the executive director shall issue a certificate of need or other notices of the decision, which shall be subject to judicial review in the same manner as are final actions of the agency.

Section 68-11-1607. (a) No person may perform the following actions in the state except after applying for and receiving a certificate of need for the same:

(1) The construction, development, or other establishment of any type of health care institution;

(2) Modification of a health care institution, other than a hospital, including renovations and additions to facilities, where such modification requires a capital expenditure greater than two million dollars ($2,000,000), or in the case of a hospital where such modification requires a capital expenditure greater than five million dollars ($5,000,000). Acquisition of real property as an investment, not for immediate use by the health care institution, shall not be deemed a modification; however, the cost of such property (or its value at the time of application, regardless of whether acquired by lease, loan, or gift) shall be included as required by agency rules as part of the total project cost of any later proposed project for the improvement, development, or use of the property in a manner which does modify the institution's facilities or services in a manner which requires a certificate of need. This provision does not apply to expenditures not directly related to patient care;

(3) In the case of a health care institution, any change in the bed complement, regardless of cost, which:

(A) Increases by one (1) or more the total number of licensed beds;

(B) Redistributes beds from acute to long-term care categories;

(C) Redistributes beds from any category to rehabilitation, child and adolescent psychiatric, or adult psychiatric; or

(D) Relocates beds to another facility or site.

(4) Initiation of any of the following health care services: air ambulance, burn unit, neonatal intensive care unit, open heart surgery, extracorporeal lithotripsy, magnetic resonance imaging, cardiac catheterization, linear accelerator, positron emission tomography, swing beds, home health, hospice, psychiatric, rehabilitation or hospital-based alcohol and drug treatment for adolescents provided under a systematic program of care longer than twenty-eight (28) days, or methadone treatment provided through a facility licensed as a non-residential methadone treatment facility.

(5) A change in the location or replacement of existing or certified facilities providing health care services, major medical equipment, or health care institutions, except for home health agencies as permitted by agency rule. "Change in location," as provided in this subdivision, shall not be construed to mean each time a piece of mobile major medical equipment is moved to a facility site for which a certificate of need has been issued;

(6) The acquisition by any person of major medical equipment for service to patients, the cost of which, exclusive of renovations or modifications, exceeds one million five hundred thousand dollars ($1,500,000); provided, that the requirements of this subdivision shall not apply to the replacement of the same or similar equipment or an upgrade of equipment which improves the quality or cost effectiveness of the service. In order to receive such exemption for replacement or upgrade of equipment, the person acquiring such replacement or upgrade shall file a written notice of such replacement or upgrade with the health services and development agency. The notice filed shall contain a description of the original equipment and the replacement or upgraded equipment, together with the cost of such equipment. The health services and development agency shall consider the information contained in the notice to determine if the replacement or upgraded equipment meets the requirements of this subdivision; and

(7) The discontinuation of any obstetrical or maternity service.

(b) No agency of the state, or of any county or municipal government, shall approve any grant of funds for, or issue any license to, a health care institution for any portion or activity thereof which is established, modified, relocated, changed, or resumed, or which constitutes a covered health care service, in a manner in violation of the provisions of this part. If any agency of the state, or any county or municipal government approves any grant of funds for, or issues any license to any person or institution that a certificate of need was required but was not granted, the license shall become void and the funds shall be refunded to the state within ninety (90) days. The agency has the authority to impose civil penalties and petition any circuit or chancery court having jurisdiction to enjoin any person who is in violation as further defined in this part.

(c)(1) Each application shall be commenced by the filing of a letter of intent. The letter of intent shall be filed between the first day of the month and the tenth day of the month, inclusive, prior to the commencement of the review cycle in which the application is to be considered. At the time of filing, the applicant shall cause the letter of intent to be published in a newspaper of general circulation in the

proposed service area of the project. The published letter of intent must contain a statement:

(A) That any health care institution wishing to oppose the application must file written notice with the agency no later than fifteen (15) days before the agency meeting at which the application is originally scheduled; and

(B) That any other person wishing to oppose the application must file a written objection with the agency at or prior to the consideration of the application by the agency.

(2) Persons desiring to file a certificate of need application seeking a simultaneous review regarding a similar project for which a letter of intent has been filed, shall file with the agency a letter of intent within ten (10) days after publication of the first filed letter of intent. A copy of any letter of intent filed after the first letter of intent shall be mailed or delivered to the first filed applicant, and shall be published in a newspaper of general circulation in the proposed service area of the first filed applicant within ten (10) days after publication by the first filed applicant. The applications shall be considered and decided by the health services and development agency simultaneously. The agency may refuse to consider the applications simultaneously, if it finds that the applications do not meet the requirements of "simultaneous review" under the rules of the agency.

(3) Applications for a certificate of need, including simultaneous review applications, shall be filed within five (5) days from the date of publication of the letter of intent. Within ten (10) days of the filing of an application for a nonresidential methadone treatment facility with the agency, the applicant shall send a notice to the county executive of the county in which the facility is proposed to be located, the member of the House of Representatives and the Senator of the General Assembly representing the district in which the facility is proposed to be located, and to the mayor of the municipality, if the facility is proposed to be located within the corporate boundaries of a municipality, by certified mail, return receipt requested, informing such officials that an application for a nonresidential methadone treatment facility has been filed with the agency by the applicant. All applications, original and simultaneous review, shall not enter the next review cycle unless filed with the agency within such time as to assure that such application is deemed complete in accordance with the rules of the agency.

(4) If there are two (2) or more applications to be reviewed simultaneously in accordance with this part and the rules of the agency, and one (1) or more of those applications is not deemed complete to enter the review cycle, the other applications that are deemed complete shall enter the review cycle. The application or applications that are not deemed complete to enter the review cycle will not be considered with the applications deemed complete and entering the review cycle.

(5) Review cycles shall begin on the first day of each of the following months: January, March, May, July, September, and November; provided, that the agency may expand the beginning of the review cycle to other months by rule. Written notice of the beginning of the review cycle will be made to all applicants deemed complete by the

agency for that review cycle. The review cycle shall also be distributed to the members of the agency. If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void. If the applicant decides to re-submit the application, the applicant shall comply with all procedures as set out by this part and a new filing fee shall accompany the application.

(6) Each application filed with the agency shall be accompanied by a nonrefundable examination fee which will be fixed by the rules of the agency.

(7) All information provided in the application or any information submitted to the agency in support of an application shall be true and correct. No substantive amendments to the application, as defined by rule of the agency, shall be allowed.

(8) Each applicant shall designate a representative as the contact person for the applicant and shall notify the agency, in writing, of the contact person's name, address, and telephone number. The applicant shall immediately notify the agency in writing of any change in the identity of the contact person or the contact person's address. In addition to any other method of service permitted by law, the agency may serve by registered or certified mail any notice or other legal document upon the contact person at such person's last address of record in the files of the agency. Notwithstanding any provisions of law to the contrary, service in the manner specified herein shall be deemed to constitute actual service upon the applicant.

(d)(1) No communications are permitted with the members of the agency once the letter of intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the executive director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the executive director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the executive director or agency staff are not prohibited.

(e) For purposes of this of this part, agency action shall be the same as administrative action defined in § 3-6-102.

(f)(1) Notwithstanding the provisions of this section to the contrary, Tennessee state veterans' homes pursuant to the provisions of Title 58, Chapter 7 shall not be required to obtain a certificate of need pursuant to this section.

(2) Notwithstanding the provisions of this section to the contrary, the beds located in any Tennessee state veterans' home pursuant to the provisions of Title 58, Chapter 7 shall not be considered by the Health Services and Development Agency when granting a certificate of need to a health care institution due to a change in the number of licensed beds, redistributing beds, or relocating beds pursuant to the provisions of this section.

(g) A hospital with fewer than one hundred (100) licensed beds may increase its total number of licensed beds by ten (10) beds over any period of one (1) year without obtaining a certificate of need. The hospital shall provide written notice of the proposed increase in beds to the agency on forms provided by the agency, prior to the hospital's request for review to the board of licensing health care facilities.

(h) After a person holding a certificate of need has completed the actions for which a certificate of need was granted, such certificate of need shall expire.

(i) The owners of the following types of equipment shall register such equipment with the health services and development agency: computerized axial tomographers, lithotripters, magnetic resonance imagers, linear accelerators and position emission tomography. The registration shall be in a manner and on forms prescribed by the agency and shall include ownership, location, and the expected useful life of such equipment. The first registration of all equipment as listed above shall be on or before September 30, 2002. Thereafter, registration shall occur within ninety (90) days of acquisition of the equipment. All such equipment shall be filed on an annual inventory survey developed by the agency. The survey shall include but not be limited to the identification of the equipment and utilization data according to source of payment. The survey shall be filed no later than thirty (30) days following the end of each state fiscal year. The agency is authorized to impose a penalty not to exceed fifty dollars ($50) for each day the survey is late.

(j) Notwithstanding the provisions of this section to the contrary, an entity, or its successor, that was formerly licensed as a hospital, and which has received from the Commissioner of Health a written determination that it will be eligible for designation as a critical access hospital under the Medicare rural hospital flexibility program, is not required to obtain a certificate of need to establish a hospital qualifying for such designation, if it meets the requirements of this subsection. In order to qualify for the exemption set forth in this subsection, the entity proposing to establish a critical access hospital must publish notice of its intent to do so in a newspaper of general circulation in the county where the hospital will be located and in contiguous counties. Such notice shall be published at least twice within a 15-day period. The written determination from the Department of Health and proof of publication required by this subsection shall be filed with the agency within ten (10) days after the last date of publication. If no health care institution within the same county or contiguous counties files a written objection to the proposal with the agency within thirty (30) days of the last publication date, then the exemption set forth in this subsection shall be applicable; provided, this exemption shall apply only to the establishment of a hospital that qualifies as a critical access hospital under the Medicare rural flexibility program and not to any other activity or service. If a written objection by a health care institution within the same county or contiguous counties is filed with the agency within thirty (30) days from the last date of publication, then the exemption set forth in this subsection shall not be applicable.

(k)(1) A nursing home may increase its total number of licensed beds by the lesser of ten (10) beds or ten percent (10%) of its licensed capacity over any period of one (1) year without obtaining a certificate of need. The nursing home shall provide written notice of the increase in beds to the agency on forms provided by the agency prior to the request for licensing by the board for licensing health care facilities.

(2) For new nursing homes, the ten (10) bed or ten percent (10%) increase cannot be requested until one (1) year after the date all of the new beds were initially licensed.

(3) When determining projected county nursing home bed need for certificate of need applications, all notices filed with the agency pursuant to § 68-11-1607(k)(1) with written confirmation from the board of licensing health care facilities that a request and application for license has been received and a review has been scheduled, shall be considered with the total of licensed nursing home beds plus the number of beds from approved certificates of need, but yet unlicensed.

(4) During such time as the provisions of § 68-11-1622 shall apply, the provisions of § 68-11-1607(k) shall be suspended.

Section 68-11-1608. (a) The Departments of Health and Mental Health and Developmental Disabilities shall review each application whose subject matter or funding is within their respective jurisdictions according to the process described in the rules of the health services and development agency. At a minimum, the reports shall provide:

(1) Verification of applicant-submitted information;

(2) Documentation or source for data;

(3) A review of the applicant's participation or non-participation in TennCare or its successor;

(4) Analyses of the impact of a proposed project on the utilization of existing providers and the financial consequences to existing providers from any loss of utilization that would result from the proposed project;

(5) Specific determinations as to whether a proposed project is consistent with the state health plan; and

(6) Further studies and inquiries necessary to evaluate the application pursuant to the rules of the agency.

(b) Upon request by interested parties or at the direction of the executive director, the staff of the agency shall conduct a fact-finding public hearing on the application in the area in which the project is to be located.

(c) Reviewing agencies shall have no more than sixty (60) days from the agency notice required by this part to file its written report with the agency. A copy of the evaluation made by the department shall be forwarded to the applicant, and to the agency, and shall be made available to others upon their request.

(d) The executive director may establish a date of less than sixty (60) days for reports on applications that are to be considered for a consent or emergency calendar established in accordance with agency rule. Any such rule shall provide that in order to qualify for the consent calendar, an application must not be opposed by any person with legal standing to oppose and the application must appear to meet the established criteria for the issuance of a certificate of need. If opposition is stated in writing prior to the application being formally considered by the agency, it will be taken off the consent calendar and placed on the next regular agenda, unless waived by the parties.

Section 68-11-1609. (a) The agency shall, upon consideration of an application and review of the evaluation and other relevant information thereon:

(1) Approve part or all of the application and grant a certificate of need for the same, upon any lawful conditions that the agency deems appropriate and enforceable on the grounds that those parts of the proposal appear to meet applicable criteria.

(A) Any such condition or conditions which are placed on a certificate of need, and which appear on the face of the certificate of need when issued shall also be made condition or conditions of any corresponding license issued by the Departments of Health or Mental Health and Developmental Disabilities. Notwithstanding any provision of law to the contrary, any such conditions survive the expiration of the certificate of need, and remain effective until removed or modified by the agency. Such conditions shall become a requirement of licensure and shall be enforced by the respective licensing entity.

(B) The holder of a license or certificate of need which has a condition placed upon it by the agency may subsequently request that the condition be removed or modified, for good cause shown. The agency will consider the request and determine whether or not to remove or modify the condition. The procedure for requesting such a determination will be as provided by agency rules. If the holder of the license or certificate of need is aggrieved by the agency's decision, it may request a contested case hearing as permitted by this part.

(2) Disapprove part or all of the application and deny a certificate of need for the same on the grounds that the applicant has not affirmatively demonstrated that those parts of the proposal meet the applicable aforementioned criteria.

(3) Defer decisions for no more than ninety (90) days to obtain a clarification of information concerning applications properly before the agency if there are no simultaneous review applications being concurrently considered by the agency with the deferred application.

(b) No certificate of need shall be granted unless the action proposed in the application is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of adequate and effective health care facilities and/or services. In making such determinations, the agency shall apply the goals, objectives, criteria and standards in the state health plan, developed in

accordance with § 68-11-1625. Additional criteria for review of applications shall also be prescribed by the rules of the agency. Notwithstanding any other provision of this subsection, when considering applications for new nursing home beds from the one hundred twenty-five (125) bed medicare skilled nursing facility bed pool authorized in § 68-11-1622, the agency shall apply the criteria in this subsection. All other applications for new nursing home beds shall be governed solely by the provisions of § 68-11-1621. During the period of July 1, 2002 to June 30, 2003, the agency shall issue no certificates of need for new nursing home beds other than the one hundred twenty-five (125) Medicare SNF beds authorized in § 68-11-1622.

(c) A certificate of need is valid for a period not to exceed three (3) years (for hospital projects) and two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the agency may, in granting the certificate of need, allow longer periods of validity for certificates of need for good cause shown. Subsequent to granting the certificate of need, the agency may extend a certificate of need for a period upon application and good cause shown, accompanied by a nonrefundable reasonable filing fee, as prescribed by rule. An extension cannot be issued to any applicant unless substantial progress has been demonstrated. A certificate of need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the agency, and is not subject to review, reconsideration, or appeal.

(d) A certificate of need which has expired is null and void, and of no effect. No revocation proceeding is required. No license or occupancy approval can be issued by the Department of Health or the Department of Mental Health and Developmental Disabilities for any activity for which a certificate of need has become null and void.

(e) The agency's decision to approve or deny an application shall be final and shall not be reconsidered after the adjournment of the meeting in which the matter was considered. This provision does not limit the right to file a petition for a contested case hearing pursuant to § 68-11-1610, nor does it limit the provisions of the Uniform Administrative Procedures Act, compiled in Title 4, Chapter 5, Part 3, pertaining to contested case hearings.

(f) Written notice of the decision of the agency approving, disapproving, or deferring an application, or parts thereof, shall be transmitted to the applicant, simultaneous review applicants, the Department of Health, the Department of Mental Health and Developmental Disabilities, and others upon request.

(g)(1) Subject to subdivision (g)(2), any health care institution wishing to oppose a certificate of need application must file a written objection with the agency and serve a copy on the contact person for the applicant, not later than fifteen (15) days before the agency meeting at which the application is originally scheduled. An application for which the agency has received opposition shall be designated on the agency's agenda as an opposed application.

(2) A health care institution or other person may appear before the agency and express opposition to an application without complying with the requirements of subdivision (1); provided, that if a health care institution does not provide notice of its opposition as required by subdivision (1), and if such health care institution initiates a contested case pursuant to § 68-11-1610, then such health care institution shall be

solely responsible for the agency's costs of the contested case proceeding and shall reimburse to the applicant the filing fee paid by the applicant, notwithstanding any other provision of law. Noncompliance with subdivision (1) shall not preclude a health care institution from intervening in a contested case proceeding initiated by the applicant.

Section 68-11-1610. (a) Within fifteen (15) days of the approval or denial by the agency of an application, any applicant, health care institution which filed a written objection in accordance with § 68-11-1609(g)(1), or any other person who objected to the application pursuant to § 68-11-1609 (g)(2), may petition the agency in writing for a hearing. Such petition shall be filed with the executive director. Notwithstanding any other provision of the law, all persons are barred from filing any petition for contested case hearing after such fifteen (15)-day period, and the agency shall have no jurisdiction to consider any late-filed petition. Upon receipt of a timely petition, the agency shall initiate a contested case proceeding as provided herein. At the hearing, no issue may be raised or evidence considered concerning the merits of an applicant considered by simultaneous review, unless the applicant met the requirements of this part of concurrent consideration with the application, which is the subject of the hearing.

(b) The contested case hearing required by this section shall be conducted in accordance with the Uniform Administrative Procedures Act, compiled in Title 4, Chapter 5, except as otherwise provided in this section.

(c) Contested cases initiated pursuant to this section shall be heard by an administrative law judge sitting alone. Petitions for contested cases received by the agency shall be forwarded immediately to the administrative division of the Secretary of State's Office for assignment to an administrative law judge.

(d) The administrative law judge to whom a case has been assigned shall convene the parties for a scheduling conference within fifteen (15) days of the date the petition for contested case is filed. At the scheduling conference, the parties shall state their respective positions on the arbitration and mediation alternatives described in this section below. If the parties are unable to agree on either the arbitration or mediation alternative, the scheduling order for the contested case adopted by the administrative law judge shall establish a schedule that results in a hearing completed within one hundred eighty (180) days of the date on which the petition for contested case was received by the agency, with the initial order to be entered within sixty (60) days of the date the hearing is completed. Extensions of time or variances from the scheduling order shall be granted sparingly, and only because of unforeseen developments that would cause substantial prejudice to a party.

(e) Initial orders of the administrative law judge in contested cases shall be reviewable upon request by the agency in accordance with the Uniform Administrative Procedures Act.

(f)(1) As an alternative to a contested case heard by an administrative law judge sitting alone, a contested case convened pursuant to this section may be decided through an arbitration process, as described herein, if all parties agree to such arbitration process.

(2) If the parties elect the arbitration process, an arbitrator shall be designated by mutual agreement of the parties, or in the event the parties cannot agree on an arbitrator, the administrative law judge to which the case is assigned shall designate an arbitrator from a list

provided by the agency staff. The arbitrator shall have no personal or business relationships with any of the parties that would require recusal under the code of judicial conduct.

(3) The scheduling order requirements set forth in (c)(2) above shall not apply to arbitration proceedings conducted pursuant to this subsection.

(4) The administrative law judge shall remain assigned to the arbitration proceeding and shall rule on all matters relative to discovery, procedures and questions of law. At the arbitration hearing, the administrative law judge shall preside in the same manner as if the administrative law judge were sitting with an agency in a contested case.

(5) The arbitrator, in his or her discretion, may develop requests for documents or data to be submitted by the parties under oath. The administrative law judge shall enforce compliance with such requests.

(6) The findings of the arbitrator shall constitute the initial order in the case, unless the administrative law judge determines that the findings are based on a mistake or are unsupported by credible evidence. In the event the administrative law judge rejects the arbitrator's findings, the administrative law judge shall adopt a substitute initial order.

(7) The initial order in an arbitration proceeding shall be reviewed by the agency in accordance with the Uniform Administrative Procedures Act.

(g) As an additional alternative to the contested case process described in (c) above, the parties may agree to mediation of the issues raised in the contested case. The mediator shall be designated by mutual agreement of the parties. The parties may designate a mediator who is not listed as a qualified Rule 31 mediator, but such mediator shall observe the standards of professional conduct set forth in Appendix A to Rule 31, to the extent applicable. The mediator's fee shall be shared equally among the parties, except the state shall not be required to contribute to payment of the mediator's fee. If mediation results in agreement of the parties, such agreement shall be memorialized in the order terminating the contested case. A mediation proceeding under this subsection shall not be subject to the scheduling order requirements set forth in (c)(2) above.

(h) The General Assembly declares the policy of the state to be that certificate of need contested cases should be resolved through arbitration or mediation, and the parties to such proceedings are encouraged to pursue these alternatives.

(i) Judicial review of the agency's final order in a contested case shall be as provided by law.

(j) All costs of the contested case proceeding, including the administrative law judge's costs, the arbitrator's fee, if any, and deposition costs, including fees of expert witnesses, shall be assessed against the losing party in the contested case. If there is more than one losing party, the costs shall be divided equally among the losing parties. No costs shall be assessed against the agency.

(k) The provisions of this section shall govern all contested cases relative to approval or denial decisions by the agency. Contested cases initiated with respect to certificate of need decisions by the Health Facilities Commission shall be conducted in accordance with the Uniform Administrative Procedures Act and not by this section.

Section 68-11-1611. The agency shall, at least annually, review progress on any project covered by an issued certificate of need, and may require a showing by the holder of such certificate of substantial and timely progress to implement the project, and if, in the opinion of the executive director, such progress is lacking, the executive director may present a petition for revocation of the certificate of need for the agency's consideration. The agency may revoke the certificate of need based upon a finding that the holder has not proceeded to implement the project in a timely manner.

Section 68-11-1612. (a) The agency, in addition to the powers and duties expressly granted by this part, is authorized and empowered to petition any circuit or chancery court having jurisdiction to enjoin any person who is performing any of the actions specified in this part without possessing a valid certificate of need for the same.

(b) Jurisdiction is conferred upon the circuit and the chancery courts of the state to hear and determine such causes as chancery causes, and to exercise full and complete jurisdiction in such injunctive proceedings.

Section 68-11-1613. The division of TennCare or its successor by the 15th of each month, shall submit to the chairs of the Senate and House Finance, Ways and Means Committees a statement reflecting the estimated impact on future state appropriations and/or expenditures of applications approved by the agency the preceding month.

Section 68-11-1614. (a) The Commissioners of Health and Mental Health and Developmental Disabilities shall establish policies and procedures to ensure independent review and verification of information submitted to the agency in applications, presentations, or otherwise.

(b) The purpose of such independent review and verification shall be to ensure that such information is accurate, complete, comprehensive, timely, and relevant to the decision to be made by the agency.

(c) The policies and procedures shall include, but not necessarily be limited to:

(1) Independent review and verification of such applicant-provided information as to the number of available beds within a region, occupancy rates, the number of individuals on waiting lists, the demographics of a region, the number of procedures, as well as any other critical information submitted or requested concerning an application;

(2) Staff examinations of data sources, data input, data processing, and data output, as well as verification of critical information through review procedures to include one (1) or more of the following:

(A) Analytical review;

(B) Tests for information on a sample basis by tracing facts to sources;

(C) Tests of all information provided, if necessary;

(D) Critical assessment of data sources, including the appropriateness of the sources; and

(E) Examination of the basis for projections of need, costs and available health services.

Section 68-11-1615. The Commissioners of Health and Mental Health and Developmental Disabilities shall establish policies and procedures to ensure independent review and verification of information submitted by health care providers for inclusion in the joint annual report.

Section 68-11-1616. Each decision rendered by the Health Services and Development Agency shall include written documentation and explanation of the factual and legal basis upon which the agency grants or denies the certificate of need.

Section 68-11-1617. (a) The agency has the power and authority, after notice and an opportunity for a hearing, to impose a civil monetary penalty against any person who performs, offers to perform, or holds such person out as performing any activity for which a certificate of need is required, without first obtaining a valid certificate of need.

(b) A civil penalty proceeding shall be initiated by the executive director of the agency with the filing of a petition with the agency. The proceeding will be conducted as a contested case hearing in accordance with the provisions of the Uniform Administrative Procedures Act, compiled in Title 4, Chapter 5, Part 3. The agency will first determine whether the person is performing, offering to perform, or holding such person out as performing any activity for which a certificate of need is required, without having first obtained a valid certificate of need. If the agency finds such a violation, the agency may impose a civil penalty, which shall begin running prospectively on the effective date of the final order as defined below in this section.

(c) The civil penalty shall be in an amount not less than one hundred dollars ($100) nor more than five hundred dollars ($500) per day of continued activity or operation, after the effective date of the final order. Notwithstanding any provision of law to the contrary, the effective date of the final order shall be the thirty-first day following entry of the final order. Once a civil penalty has been imposed, the violator shall have the burden of submitting verifiable evidence satisfactory to the agency, that the violator has discontinued the activity for which the civil penalty was imposed. The penalty shall accrue from the effective date until such evidence of discontinuance is received at the agency office.

(d) If the violator does not appeal to chancery court pursuant to § 4-5-322, the penalty shall become due and payable on the sixty-first day following entry of the final order. If the violation continues, the amount of the civil penalty will continue to accrue, and the violator shall make monthly payments of the accrued amount to the agency.

(e) If an appeal is taken pursuant to § 4-5-322, the penalty shall be due and payable on the thirty-first day following entry of an order of the final appellate court ruling on the matter, if the penalty is upheld. If the violation continues during the pendency of the appeal, the amount of the penalty will continue to accrue. If the violator fails to pay the civil penalty when due, the agency may apply to the chancery court of Davidson County to have the penalty converted to a judgment, and seek execution of such judgment. In any such proceeding, the chancery court shall convert the civil penalty to a judgment unless the court finds the agency acted in the clear absence of any jurisdiction whatsoever.

(f) In determining whether to impose a civil penalty and the amount thereof, the agency may consider the following factors:

(1) The economic benefits gained from the activities in question. The agency does not have to show that the violator would not have been granted a certificate of need had one been sought;

(2) Whether the civil penalty and the amount thereof, will be a substantial economic deterrent to the violator and others;

(3) The circumstances leading to the violation, and whether the violator had notice that the activity was in violation of the certificate of need laws and/or agency regulations; and

(4) The financial resources of the violator, and the violator's ability to pay the penalty.

Section 68-11-1618. Notice must be made to the agency of change of ownership occurring within two (2) years of the date of the initial licensure of a health care institution. Such notice must be made within thirty (30) days of the change of ownership and must include documentation of the commitment from the subsequent owner to comply with all conditions placed on the original certificate of need, and on the license, pursuant to this part.

Section 68-11-1619. (a) In addition to any other grounds for revocation provided by other statutes, rule of law, or equity, the agency has the power to revoke a certificate of need whenever any of the following has occurred:

(1) The holder of a certificate of need has not made substantial and timely progress toward the completion of the project or acquisition of the equipment;

(2) The acquisition or project as described in the person's application has been changed or altered in such a manner as to significantly deviate from the acquisition or project approved by the agency when the certificate of need was granted;

(3) The decision to issue a certificate of need was based, in whole or in part, on information or data in the application which was false, incorrect, or misleading, whether intentional or not;

(4) The holder of the certificate of need has committed fraud in obtaining the certificate of need or has committed fraud upon the agency after the certificate of need was issued. For purposes of this section, "fraud" means any form of deceit, trickery, misrepresentation, or subterfuge, including, but not limited to, any of the following actions:

(A) Making a knowingly false statement, orally or in writing, in connection with a certificate of need application or project subject to the jurisdiction of the agency;

(B) Intentionally withholding or suppressing information which the person knows, or reasonably should know, is relevant to a certificate of need application or project subject to the jurisdiction of the agency;

(C) Altering, forging, or otherwise modifying, with fraudulent intent, any document submitted to the agency in connection with any certificate of need application or project subject to the jurisdiction of the agency; or

(5) The violation of any condition placed upon a certificate of need by the agency, prior to licensure by the Department of Health or Department of Mental Health and Developmental Disabilities.

Section 68-11-1620. (a) Except as provided in this section, the transfer of a certificate of need shall render it and all rights thereunder null and void. As used in this section, "transfer" means:

(1) Any sale, assignment, lease, conveyance, purchase, grant, donation, gift or any other direct or indirect transfer of any nature whatsoever of a certificate of need; provided, that nothing herein shall prohibit the transfer of a certificate of need, other than a certificate of need for the establishment of a new health care institution, if the certificate of need is transferred as part of the transfer of ownership of an existing health care institution;

(2) With regard to a certificate of need for the establishment of a proposed new health care institution, a change of control of the entity prior to completion or licensing shall render the certificate of need and all rights thereunder null and void. "Change of control" means:

(A) In the case of a partnership, the termination of interest of a general partner.

(B) In the case of a limited liability company or limited liability partnership, a change in the composition of members or partners to the extent that the management or membership control is different than that described in the certificate of need application.

(C) In the case of a corporation, the termination of interest of a shareholder or shareholders controlling more than fifty percent (50%) of the outstanding voting stock of the corporation.

(D) Nothing in subdivision (a)(2) shall prohibit change of control as described herein if the agency determines, upon petition of the prospective owner or owners of the entity, that such prospective owner or owners demonstrate that they meet the criteria of economic feasibility, contribution of orderly development and the considerations of Section 68-11-1605.

(b) A certificate of need, and the rights thereunder, shall be null and void if it is the subject of a development contract or agreement to sell or lease the facility that was not fully disclosed in the application.

Section 68-11-1621. (a) Notwithstanding the provisions of the state health plan or any regulation of the agency, the provisions of this section establish the criteria for issuance of certificates of need for new nursing home beds regardless of site (including conversion of any beds to licensed nursing home beds). The agency is authorized to grant a certificate of need only if the applicant meets all of the requirements of this section.

(b) The first criterion which must be met is the need for the project:

(1) The need for nursing home beds shall be determined by applying the following population-based methodology:

County bed need = .0004 times population of the county sixty-five (65) years of age and under; plus,

0.01 x population age 65-74; plus,
0.04 x population age 75-84; plus,
0.15 x population age 85 and over.

When applying the foregoing bed need formula, the agency shall use the formula in effect at the time of initial consideration of an application rather than a formula in effect at the time of application. County population statistics shall be based upon official statistics provided by the Department of Health;

(2) The need for nursing home beds shall be projected two (2) years into the future from the current year; and

(3) The actual bed need shall be derived by subtracting the projected bed need from a bed total comprised of the number of nursing home beds licensed in the county plus certificate of need approved, but yet unlicensed beds.

(c) The second criterion which must be met is economic feasibility:

(1) The application must show and the agency must find that the project will meet or exceed the following parameters:

(A) A debt service coverage ratio greater than or equal to 1.25 by the end of the second year of projection. Debt service coverage ratio is net income before depreciation and interest expense divided by the annual debt service;

(B) A current ratio greater than or equal to 1.25 by the end of the second year of projections. Current ratio is current assets divided by current liabilities;

(C) Day's cash on hand greater than or equal to fifteen (15) days at the end of each year of projection. Day's cash on hand is cash plus equivalents divided by net operating expenses per day minus depreciation per day; and

(D) Long term debt as a percent of total capital less than or equal to ninety percent (90%). Long term debt as a percent of total capital is long term debt divided by long term debt plus shareholders' equity or fund balance; and

(2) The applicant must show and the agency must evaluate the project with reference to:

(A) Whether sufficient financial resources are available to implement and operate the project including levels of patient charges and proof of potential capital financing;

(B) The long range amortization of the project plus any cost associated with the original building if the proposed project is an addition or conversion of current space;

(C) A comparison of the cost of similar projects, including any construction costs, during the preceding year; and

(D) Projection of total costs over expected life of facility.

(d) When considering simultaneous review of two (2) or more applications for nursing home beds in the same county the agency shall consider the following criteria in addition to need and economic feasibility:

(1) Any unique qualities or characteristics the application exhibits that distinguish it from other nursing homes, in the form of clientele served or services offered;

(2) The extent to which each project proposes to meet any unmet needs of the area's population; and

(3) The comparative costs of the projects. In simultaneous review applications the focus shall be more on comparing the cost to the patient or payment source than a comparison of per bed or per square foot costs.

(e) The agency shall not approve the settlement of an appeal of the denial or issuance of a certificate of need if such settlement approves a project which does not meet the requirements of this section.

Section 68-11-1622. (a) During the fiscal year July 1, 2002 to June 30, 2003, the agency shall issue no certificates of need for new nursing home beds, including the conversion of hospital beds to nursing home beds or swing beds, other than one hundred twenty-five (125) beds per fiscal year, to be certified as Medicare skilled nursing facility (SNF) beds as authorized in this section.

(b) The number of Medicare SNF beds issued under this subsection shall not exceed thirty (30) for each applicant. The applicant shall specify in the application the skilled services to be provided and how the applicant intends to provide such skilled services. In reviewing applications, the agency shall consider the application without regard as to whether the applicant currently has Medicare SNF beds. Applications for Medicare SNF beds under this subsection shall be reviewed by the department and considered by the agency pursuant to § 68-11-1609, rather than § 68-11-1621. If the pool of one hundred twenty-five

(125) Medicare SNF beds created by this subsection is not depleted prior to June 30 of the fiscal year, the beds remaining in such pool shall be considered to be available to applicants who apply before June 30 of each fiscal year, even though review may occur after June 30 of that year.

Section 68-11-1623. All fees authorized by this part shall be maintained in a separate account administered by the Health Services and Development Agency. Fees include, but are not limited to, fees for the application of certificates of need, subscriptions, project cost-overruns, copying and contested cases. The account is established for the purpose of providing support for the implementation of the certificate of need program, data collection and the administration of the agency. It is the intent of the General Assembly that the funds in this account shall not revert to the state general fund, but shall instead be carried forward for the purpose for which they were originally intended. It is also the intent of the General Assembly that any accumulated revenues in excess of expenditures of the Health Facilities Commission upon the date the Health Facilities Commission ceases to exist shall be deposited in the agency account as created by this part for the administration of the certificate of need program. Furthermore, it is the intent of the General Assembly that funds allocated for the fiscal year 2001-2002 for the Health Facilities Commission shall fund the Health Services and Development Agency for the remainder of that same fiscal year. The executive director shall prepare a budget for submission and approval of the General Assembly for each fiscal year thereafter.

Section 68-11-1624. At a hearing conducted by the agency for a nonresidential methadone treatment facility, if a local governing body requests to participate in such hearing, the officials of such governing body shall have the opportunity to appear before the agency and express support and/or opposition to the granting of a certificate of need to the applicant. The testimony of such officials shall be informational and advisory to the agency and the support of the local governing body shall not be a requirement for the granting of a certificate of need by the agency.

Section 68-11-1625.

(a)(1) There is created a state health planning and advisory board composed of thirty-four (34) members. Twenty-four (24) members shall be appointed by the Governor, three (3) appointed by the Speaker of the Senate, and three (3) appointed by the Speaker of the House of Representatives. The Commissioners of the Departments of Health and Mental Health and Developmental Disabilities shall serve as ex officio voting members. The Chairmen of the Finance, Ways and Means Committees of the Senate and the House of Representatives shall serve as ex officio voting members. The members appointed by the Governor shall be composed as follows:

(A) One (1) member from a medical school located in Tennessee;

(B) One (1) member who is a physician/surgeon as recommended by the Tennessee Medical Association or other similar major statewide association;

(C) One (1) member who is a registered nurse as recommended by the Tennessee Nurses Association or other similar major statewide association;

(D) One (1) member representing county governments as recommended by the Tennessee County Services Association or other similar major statewide association;

(E) One (1) member representing municipal governments as recommended by the Tennessee Municipal League or other similar major statewide association;

(F) One (1) member representing rural hospitals as recommended by the Tennessee Hospital Association or other similar major statewide association;

(G) One (1) member representing government owned hospitals as recommended by the Tennessee Hospital Association or other similar major statewide association;

(H) One (1) member representing public and teaching hospitals as recommended by the Tennessee Hospital Association or other similar major statewide association;

(I) One (1) member representing urban hospitals as recommended by the Tennessee Hospital Association or other similar major statewide association;

(J) One (1) member representing rural nursing homes as recommended by the Tennessee Health Care Association or other similar major statewide association;

(K) One (1) member who is a primary care physician as recommended by the Tennessee Medical Association or other similar major statewide association;

(L) One (1) member representing the private insurance industry as recommended by the Tennessee Farm Bureau Federation or other similar major statewide association;

(M) One (1) member representing urban nursing homes as recommended by the Tennessee Health Care Association or other similar major statewide association;

(N) One (1) member representing home health agencies as recommended by the Tennessee Association of Home Care or other similar major statewide association;

(O) One (1) member representing hospices as recommended by the Tennessee Association of Home Care or other similar major statewide association;

(P) One (1) member representing small businesses as recommended by the Tennessee chapter for the National Federation of Independent Business or other similar major statewide association;

(Q) One (1) member representing organizations for the population over the age of sixty-five (65) years as recommended by the AARP or other similar major statewide association;

(R) One (1) member representing providers of mental health services as recommended by the Tennessee Association of Mental Health Organizations or other similar major statewide association;

(S) One (1) member representing the providers of developmental disability services as recommended by the Tennessee Disability Association or other similar major statewide association;

(T) One (1) member representing the state insurance committee;

(U) One (1) member representing labor as recommended by the Tennessee AFL-CIO labor council or other similar major statewide association;

(V) One (1) member representing organizations for indigent and underserved populations as recommended by the Tennessee Justice Center;

(W) One (1) member representing a business with more than one hundred fifty (150) employees as recommended by the Tennessee Association of Business or other similar major statewide association; and

(X) One (1) member recommended by the Volunteer State Medical Association.

(2) The terms of the appointments shall be three (3) years. The terms shall be staggered so that the initial term for the first eight (8) members shall be one (1) year; the initial term for the second eight (8) members shall be two (2) years; and the term for the remaining eight (8) members shall be three (3) years. The speakers shall make their initial appointments designating one for a term of one (1) year, one for a term of two (2) years and one for a term of three (3) years. Following the initial terms, all terms shall be three (3) years. No member shall serve more than two consecutive, three-year terms.

(3) In making appointments to the state health planning and advisory board, the Governor and the speakers shall strive to ensure that racial minorities, females, and persons sixty (60) years of age are represented.

(4) The members appointed by the speakers shall be persons who are knowledgeable of health needs and services and representative of the consumers of health care in Tennessee. The members shall not be a direct provider of health care goods or services.

(5) Members of the board shall be subject to removal by the Governor or the speakers accordingly for neglect of duty or failure to

attend at least 75% of the meetings of the board in any year. Vacancies shall be filled by the Governor or speakers as appropriate.

(6) The member representing a medical school located in Tennessee shall serve as chairperson.

(7) Twenty-two (22) members shall constitute a quorum. The members shall elect a vice-chairman at the first meeting of the fiscal year.

(8) Members of the board that are not employed by the state will not be paid for their service. Each member will be reimbursed for travel expenses in accordance with the provisions of the comprehensive travel regulations as promulgated by the Department of Finance and Administration.

(9) A separate account is authorized to provide support for the state health planning and advisory board. The following schedule of fees from healthcare providers shall be collected annually and administered by the Health Services and Development Agency. The account shall be used for the services required to fulfill the duties of the state health planning and advisory board. All planning staff shall be hired by and under the direction of the executive director of the Health Services and Development Agency. The following schedule shall apply:

(A) Residential hospice---$100 per license;

(B) Nursing homes---$100 per license;

(C) Hospitals 1-100 beds---$100 per license;

(D) Hospitals 101-200 beds---$200 per license;

(E) Hospitals 201+ beds---$300 per license;

(F) Ambulatory surgical treatment centers---$100 per license;

(G) Outpatient diagnostic centers---$100 per center;

(H) Home care organizations---$100 per license;

(I) Homes for the aged---$50 per license;

(J) Birthing centers---$50 per license;

(K) Assisted living facilities---$100 per license;

(L) Alcohol and drug facilities (including non-residential methadone treatment facilities)---$75 per license;

(M) Mental health hospitals 1-100 beds---$100 per license;

(N) Mental health hospitals 101+ beds---$200 per license;

(O) Mental health residential treatment facilities---$100 per license; and

(P) Mental retardation institutional habilitation facilities---$100 per license.

(b) It is the purpose of the board to develop a state health plan that is evaluated and updated at least annually. The plan shall guide the state in the development of health care programs and policies, and the allocation of health care resources in the state.

(c) It is the policy of the State of Tennessee that every citizen have reasonable access to emergent and primary care; that the state's health care resources are developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies and the continued development of the state's health care industry; that every citizen can have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers and that the state supports the recruitment and retention of a sufficient and quality health care workforce.

(d) The board shall be staffed administratively by the agency until such time that the agency has developed a planning and data resources staff. The agency staff shall coordinate the agendas and request the assistance of other agencies such as the Departments of Health and Mental Health and Developmental Disabilities to assist in the areas and programs under their jurisdiction by providing testimony, data and reports.

(e) The duties and responsibilities of the board include:

(1) To develop and adopt a state health plan;

(2) To submit the plan to the Health Services and Development Agency for comment;

(3) To submit the state health plan to the Governor for his approval and adoption;

(4) To hold public hearings as needed;

(5) To review and evaluate the plan at least annually;

(6) To respond to requests for comment and recommendations for health care policies and programs;

(7) To conduct an ongoing evaluation of Tennessee's resources for accessibility, including but not limited to financial, geographic, cultural, and quality of care;

(8) To review the health status of Tennesseans as presented annually to the board by the Department of Health and the Department of Mental Health and Developmental Disabilities;

(9) To review and comment on federal laws and regulations that influence the health care industry and the health care needs of Tennesseans;

(10) To involve and coordinate functions with such state entities as necessary to ensure the coordination of state health policies and programs in the state;

(11) To prepare an annual report for the General Assembly and recommend legislation for their consideration and study; and

(12) To establish a process for timely modification of the state health plan in response to changes in technology, reimbursement and other developments that affect the delivery of health care.

(f) At the first meeting of the board, the members shall review current criteria and standards developed by the Health Planning Commission in 2001, and adopt the criteria and standards as guidance for the issuance of certificates of need until such time as a new state health plan is developed. The board may make subsequent changes to the criteria and standards pending development of the new state health plan.

Section 68-11-1626. After appointment of the Health Services and Development Agency members pursuant to this part, such members shall meet as soon as practicable for organizational and other purposes. It is the intent of the General Assembly that the agency shall be fully and solely responsible for administration of the certificate of need process on July 1, 2002. Jurisdiction of the agency over the certificate of need process shall be effective simultaneously with the cessation of the Health Facilities Commission, and there shall be no period in which a certificate of need is not required for the actions set forth in § 68-11-1607.

SECTION 5. The rules and regulations promulgated by the Health Facilities Commission as of the effective date of this act shall remain in effect and become the rules and regulations of the Health Services and Development Agency until the agency promulgates new rules and regulations; provided, however, those rules and regulations of the Health Facilities Commission contrary to this act shall be null and void as of July 1, 2002.

SECTION 6. This act shall not affect rights and duties that matured, penalties that were incurred or proceedings that were begun before its effective date by the agency existing prior to the effective date. It is the intent of the General Assembly that all pending applications, contested cases and other matters proceed without interruption during the transition of authority between the Health Facilities Commission and the Health Services and Development Agency. After the Health Facilities Commission ceases to exist, the Health Services and Development Agency shall succeed to all the rights, powers and interests relative to such applications, contested cases and other matters. All rights and conditions assigned to existing certificates of need shall continue.

SECTION 7. (a) It is the intent of the General Assembly that all property assigned to the Health Facilities Commission be transferred to the Health Services and Development Agency. The agency shall have full authority over all administrative and budget processes transferred to the agency from the Health Facilities Commission.

(b) Recognizing the years of faithful and dedicated service to the State of Tennessee by the employees of the Health Facilities Commission, it is the intention of the General Assembly that those employees who serve in jobs that would be classified as career service, as defined in § 8-30-208, receive the

benefits and protection of career service status upon passage of this act without further examination or competition, provided that such employees must have completed at least six (6) months of service with the Health Facilities Commission upon the effective date of this act.

(c) In addition to the designations of career service and executive service in § 8-30-208, the following shall be included in the executive service:

(1) The executive director of the agency; and

(2) Any attorneys employed by the agency.

(d) The executive director shall be appointed by the agency in accordance with § 68-11-1606 at the first meeting of the agency and serve as the appointing authority for the agency. All other executive service staff shall serve at the pleasure of the appointing authority. During the time period between the effective date of this act and the appointment by the agency of an executive director, the executive director of the Health Facilities Commission shall serve as the interim executive director with oversight and consultation by the Comptroller of the Treasury. The interim director shall have all the responsibilities, powers and duties delegated to the executive director of the agency by this act.

SECTION 8. If any provision of this act of the application of it to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the act that can be given effect without the invalid provision or application, and to that end the provisions of this act are declared to be severable.

SECTION 9. The act shall take effect upon becoming law, the public welfare requiring it.

PASSED: May 22, 2002

JOHN S. WILDER
SPEAKER OF THE SENATE

JIMMY NAIFEH, *SPEAKER*
HOUSE OF REPRESENTATIVES

APPROVED this 29th day of May 2002

DON SUNDQUIST, GOVERNOR